Appendix 3
EarlySteps Forms

Referral

Referral Form
Acknowledgement Letter (SPOE Use only)
Access Log (SPOE Use and FSC Use)

Intake

All forms initially SPOE Use Only; those marked with an ** are updated periodically by FSC

1) Notice of Action & Consent to Proceed for Initial Eligibility Determination & IFSP Development
2) Notice of Action: Eligibility Refused
3) DHH Application for Services 0-3 with Special Needs**
4) Dissemination Instructions for DHH Application
5) Assessment Guidelines/Format
6) Health Summary (mailed to medical home)
7) Health History**
8) Consent to Release & Share Information**
9) Provider Selection Form
10) Family Assessment of Concern, Priorities & Resources**
11) Team Meeting Announcement
12) SPOE Checklist

Eligibility—All forms are used by SPOE and FSC

Request for Authorization
Eligibility Consultant Statement
Eligibility Determination Documentation
Eligibility Information for OCDD or BCSS Referrals

IFSP—SPOE use IFSP only; all other forms are used by FSC

1) IFSP
2) IFSP 6-Month Review
3) IFSP Revision
4) IFSP Authorization Change Form
5) Notice of Action: Re-determination of Eligibility
6) Notice of Action: IFSP Revisions
7) Request for Authorization
8) FSC Quarterly Report
9) Team Meeting Announcement
10) Parent Request Change of Provider
11) Provider Selection Form
12) Provider Monthly Report

Transition—SPOE and FSC use

Case Closure/Transfer/Transition Form
Transition Notification to LEA

Other Forms—SPOE and FSC use as needed for individual situations

Consent to Bill Insurance
Consent for Specialized Assessment
Data Correction Form
Change of Information Form
Parent Request to Change Provider Form
Surrogate Parent Determination Form
Provider Change of Information Form
FSC Billing Form

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REFERRAL FORM

SPOE Only
Date Received: _____
Date Intake Coor Assigned:_____
Date Entered:_____
Date Acknowledgement Sent:_____

Child Information

* Name: _____ *Date of Birth: _____
Last/First/Middle MM/DD/YYYY

*Address: _____
Apartment/Street/ PO Box City/Town Zip

Family Information

*Parent's name:_____ *Relationship:☐ mother ☐ father
☐ other: _____

*Address: _____
Apartment/Street/ PO Box City/Town Zip

*Home telephone: ____-____-_____ Work telephone: ____-____-_____
(###-###-####) (###-###-####)

***Reason for Referral: Check one; please provide additional comments as noted.**

☐ Suspected developmental delay in at least one area of development
☐ physical, including vision or hearing ☐ cognitive ☐ adaptive (self-help) ☐ communication ☐ social-emotional

☐ Suspected medical condition associated with developmental disability or developmental delay
Diagnosis (if known):_____

REFERRAL SOURCE INFORMATION
Name: _____

Address: _____
Apartment/Street/ PO Box

_____
City/Town

Work telephone: ____-____-_____ FAX number: ____-____-_____
(###-###-####) (###-###-####)

***What is your role? Circle one:**
Parent; Relative; Friend; NICU; MCH Clinic-KIDMED; Physician; Central Directory, Daycare; Hospital ; State agency: OCS , OFS, Mental Health, OCDD; Early Intervention Program; Education Agency (LEA); Early /Head Start; Family Support Agency; Hospital Diagnostic Program; Regional Council; Community Mental Health Agency; Psychiatrist; Public Health Nurse; Community Social Service Agency; State Operated Facility; WIC

***How did you find out about EarlySteps? Circle one:**
State agency: OCS, OFS, Mental Health, OCDD; Early Intervention Program; Education Agency (LEA); Early /Head Start; Family Support Agency; Regional Council; Community Mental Health Agency; Parent; Psychiatrist; Public Health Nurse; Community Social Service Agency; State Operated Facility; WIC; Relative; Friend; NICU; MCH Clinic-KIDMED; Physician; Advertising: TV, Radio, Print, Billboard, Central Directory, Daycare; Hospital; Hospital Diagnostic Program

Please mail or FAX to: [SPOE ADDRESS and FAX]

Template for Acknowledging Referrals

DATE

REFERRAL SOURCE NAME
Address

Dear _____

Thank you for referring_(child's name)__ to the Louisiana Part C Early Intervention System. We appreciate your interest in the well being of young children.

We have started the intake process with the family, following the procedures for the Part C system. This includes, with the family's consent, determining eligibility. If __(child's name)__ is found eligible and the family agrees, we will then develop an Individualized Family Service Plan (IFSP). These activities must be completed within 45 days of the receipt of the referral.

We gladly share information from the early intervention record if the parent gives written permission to do so. If you would like to have periodic updates or be a part of this child's team, please contact the family so that they may consider your request. We are unable to provide additional personally identifiable information without the permission of the parent.

Again, thank you for the referral.

Sincerely,

SPOE

EarlySteps Early Intervention
Record Access Log

Child's Name:_____ _DOB: _____

Date	Name	Title/Agency	Purpose of Review

This must be present in each child's file.

Intake Forms

NOTICE OF ACTION AND CONSENT FOR INITIAL ELIGIBILITY DETERMINATION & IFSP DEVELOPMENT

Date Notice Provided to Family:_____

Notice of Action: The EarlySteps system of early intervention proposes to evaluate information about my child to determine if my child is eligible for EarlySteps. An assessment of my child may be conducted if needed to gather information about my child's current functioning and needs. If my child meets the eligibility criteria for EarlySteps, an Individualized Family Service Plan will be developed that specifies the developmental outcomes desired for my child and family and the early intervention services necessary to achieve those outcomes. I understand that EarlySteps can take no action for 3 days and that I can refuse or contest any action taken by EarlySteps.

Along with this Notice of Action, I received a brochure, which describes the rights, opportunities, and responsibilities available to me (Parents Rights). I understand that the early intervention providers will follow procedures to assure that my rights and those of my child are guaranteed. The Parents Rights includes information regarding:

(1) Evaluation for Eligibility Determination, and Assessment Service(s) for eligibility determination and/or IFSP development,
(2) Six Month Review and Annual Evaluation of the IFSP,
(3) Confidentiality of Information,
(4) Procedures for filing complaints; and
(5) Mediation and Due Process Hearings.

My rights, opportunities and responsibilities were explained to me, both verbally and in writing.

Consent to Proceed: I, therefore, grant permission for EarlySteps, Louisiana's Early Intervention System to proceed with the eligibility evaluation to determine eligibility. I understand that assessments of my child's developmental skills may be conducted to assist with eligibility or with the development of the IFSP. If my child is eligible, I understand that an IFSP will be developed. I understand that, as my child's parent/legal guardian, that I am an active and equal member of the early intervention team for the purposes of determining my child's eligibility for Early Steps and subsequent IFSP development if appropriate. I understand that I can revoke this consent at anytime.

Child's Name:_____

_____ _____
Parent/Legal Guardian /Educational Surrogate Date

_____ _____
Intake/Family Service Coordinator Date

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Notice of Action for Eligibility

Notice of Action

Written prior notice must be given to the parents of a child eligible under Early Steps (Part C) in a reasonable time before a public agency or service provider proposes, or refuses, to initiate or change the identification, evaluation, or placement of the child, or the provision of appropriate early intervention services to the child or the child's family.

IMPLEMENTATION IN EARLY STEPS SYSTEM

1. Check if the action is being proposed or refused

2. Write the child's name in the blank marked "child's name".

3. Enclose a copy of the Parent's Rights Brochure and mail to the family. Also Insert a copy in the in the early intervention record for this child.

SPOE use only

Notice of Action: Eligibility Refused

Date Notice Provided to Family:_____

A Notice of Action must be given to you before certain actions are taken. The following is to inform you of the action refused on behalf of your child,

_____.
Child's name

Reason for the Action:
We administered an Ages and Stages Questionnaire (ASQ) which is a screening instrument. We also completed a Family Assessment of the Child's Development and gathered health status information from your child's medical home. The ASQ results indicated that there are no developmental concerns for your child.

This information, paired with the other sources of information, indicates there are no developmental concerns that warrant further investigation (testing). Therefore, EarlySteps is refusing to evaluate your child for eligibility.

This notice invokes specific rights for parents. Please refer to your Parent's Rights Statement. If you need assistance in understanding the provisions of the Parent's Rights Statement, you may contact the Early Steps office at 1-800-730-8030.

If you have any questions or object to this action, please contact me within 3 days.

Name of Intake Service Coordinator:

_____

Name Phone number

For SPOE use only

Date Filed by SPOE: _____

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FOR SPOE/FSC USE ONLY:
Date Sent to Medicaid: _____

Date Sent to OCDD: _____

Date Sent to OCDD/BCSS/ MRDD for Registry: _____

Date Sent to CSHS: _____

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
APPLICATION FOR SERVICES CHILDREN 0-3 WITH SPECIAL NEEDS

* Indicates information is entered and stored electronically at the System Point of Entry ✓ Indicates Required for EarlySteps

Part 1. Enrollment Application

*CHILD'S PARISH OF RESIDENCE	Intake/Request/APPLICATION Date	TIME OF REQUEST/APPLICATION

✓SECTION A. *CHILD INFORMATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER

MAILING ADDRESS	CITY/STATE/ ZIP CODE	TELEPHONE NUMBER	MOTHER'S MAIDEN NAME
		( )	

CHILD'S NATIVE LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ VIETNAMESE ☐ OTHER:_____

✓SECTION B. ENROLLMENT REQUESTS THIS IS A REQUIRED SECTION

Medicaid/La Chip Status	☐ Applying Now	☐ Already Receiving Coverage: **Number:** _____	☐ Not Interested
Office for Citizens with Developmental Disabilities (OCDD) services	☐ Applying Now	☐ Already Receiving Coverage	☐ Not Interested
Children's Special Health Services (CSHS)	☐ Applying Now	☐ Already Receiving Coverage	☐ Not Interested
BCSS/MRDD Request for Services Registry	☐ Requesting Services Now	☐ Not interested at this time. I understand that by marking this box, the Intake/Request/Application Date will not be my child's **Protected Date for the MR/DD RFSR.** SIGNED: DATE:	

✓SECTION C. *PARENT/LEGAL GUARDIAN INFORMATION

1. Name: _____

Address: _____
Street City State Zip Code

Home Telephone: _(_____)_____ Work Telephone: _(_____)_____Other Telephone: _(_____)_____

2. Name: _____

Address: _____
Street City State Zip Code

Home Telephone: _(_____)_____ Work Telephone: _(_____)_____ Other Telephone: _(_____)_____

Native language spoken at home:_____ Interpreter needed? Y/N

SECTION D. Information about the child's parents, brothers, or sisters under age 19 who live in the home.

①You **DO NOT** have to give a Social Security number if you **ARE NOT** applying for Medicaid.

② Race information DOES NOT have to be given for Medicaid application.

* ***Part C requires Race information only for the child enrolling in Part C services.*** *Use the following codes: 1=White; 2=African-American; 3=American Indian/Alaskan; 4=Asian; 5=Hispanic/Latino; 6=HI/Pacific Islander; 7=Hispanic/Latino & Other; 8=Multi-Race Not Hispanic; 9=Unknown.*

Name - First, Middle Initial, Last	Applying for coverage? Y/N	Social Security Number①	Date of birth			Sex M/F	U.S. Citizen Y/N	Race □	Relation to child (brother, sister, mother, father.)
			Month	Day	Year				

SECTION E. Income This section is required for all applicants.

√*Who is the head of household?_____

Does anyone in your household work or is self-employed? YES NO If YES, complete the following. Give us gross income before deductions, not take home pay. (Required for Medicaid application)

Name of the person working	Name, address, phone # of the company or person you work for	Amount paid per hour	Number of hours worked/week	How often do you get paid?	Monthly Income
		$			$
		$			$

Does anyone in your household get any other money such as the kinds listed below? □ YES □ NO If YES, complete the following.

Source of money	Who does the money come from? Name and address.	Who gets this money?	How much?	How often?
Social Security/ SSI			$	
Child Support/Alimony			$	
Money from friends or relatives			$	
Other sources of money			$	

What is the Total Household Gross (before deductions) MONTHLY Income? $_____

Is this month's income the same as the previous three months? YES NO

Are you currently paying child care to be able to go to work? YES NO If YES, how much a month? $_____

Do you pay for care of an incapacitated adult? YES NO If YES, how much a month $_____

Does anyone living in the household pay child support or alimony? YES NO If YES, how much a month $_____

Do you have extraordinary expenses? YES NO

Is your child blind or disabled? YES NO

SECTION F. Medical Insurance This section is required for all applicants.

PRIMARY INSURANCE COMPANY:

Name: _____ Telephone: _(_____)_____

Address: _____

Street City State Zip Code

Policy/Group #: _____ Member/ID #: _____ Start date: _____ End date: _____

POLICY HOLDER INFORMATION:

Name: _____ Telephone: _(_____)_____

Address: _____

Street City State Zip Code

COVERAGE INFORMATION:

A. Secondary Insurance Coverage? ☐ YES ☐ NO

B. Therapy Services Covered: ☐ OT ☐ PT ☐ Speech

C. Co- Payments? ☐ YES ☐ NO

D. Deductibles? ☐ YES ☐ NO

F Maximum Out of Pocket Expense $

F. Is there a pre-existing clause? ☐ YES ☐ NO

G. Lifetime maximum? ☐ YES ☐ NO

I. Conditions /Exclusions: _____

_____

SECTION G. <u>Rights and Responsibilities under Medicaid</u>

- I declare that everyone who is applying for health insurance is a U.S. citizen or is in this country legally. The information I give on this form is true and correct to the best of my knowledge. I realize if I knowingly give information that isn't true OR if I knowingly withhold information and my child(ren) get health benefits for which they are not eligible, I can be lawfully punished for fraud and I may have to re-pay Medicaid for any medical bills which are paid incorrectly.
- I understand that the information I give about our situation will be checked. I agree to help do that and to let Medicaid get needed information from government agencies, employers, medical providers and other sources.
- I know that our Social Security numbers will only be used to get information from other government agencies to prove eligibility.
- I understand by accepting Medicaid/La CHIP, I give the Department of Health and Hospitals the right to any medical support or payments from third parties who would be legally responsible for any medical services paid by Medicaid for my child(ren). I agree to release any medical information needed by the Medicaid Program or others for the purpose of paying or receiving payment of medical bills. I understand that this is required to get coverage and I agree to help in obtaining medical support and payments from anyone who is legally responsible.
- I understand that Medicaid will **only** make a referral to Child Support Enforcement for medical support upon my request.
- I agree to tell Medicaid within 10 days of the following changes: 1) If anyone receiving health coverage moves out of state; 2) Changes where we live or get our mail; and 3) Changes in other health insurance coverage.
- I can ask for a Fair Hearing if I think the decision made on my case is unfair, incorrect or being made too late.
- Medicaid can't discriminate because of race, color, sex, age, disability, religion, nationality or political belief. If I think they have, I can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1+800+368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 1349 Baton Rouge, LA 70821-1349.
- Information about WIC, KIDMED and other Medicaid services will be sent to me if we are eligible for Medicaid.

The required signature below documents the completion of this entire form by the parent or authorized representative, regardless of which programs the child/family is applying for enrollment.

_____ _____

Signature of Parent or Authorized Representative Date

Intake Coordinator/Interviewer _____Telephone: _____

Medicaid/La Chip: A copy of the LA DHH Application for Services Form is sent to the Parish Medicaid office with a cover letter stating that this family is interested in applying to Medicaid. **This must be mailed no later than 15 calendar days of receipt of referral.**

Office for Citizens with Developmental Disabilities (OCDD) Services, including the Capital Area Human Services District, Metropolitan Human Services Authority and Jefferson Parish Human Services Authority:

- The **DATE OF APPLICATION** as listed on the following EarlySteps forms is very important:
  1. " EarlySteps of Louisiana Eligibility Notification for OCDD and BCSS Referrals "
  2. "The Louisiana Department of Health and Hospitals Application for Services Children 0-3 with Special Needs" (under Intake/Application Date) is the child's **PROTECTED DATE** for future services***** through the Office for Citizens with Developmental Disabilities, Capital Area Human Services District, Metropolitan Human Services Authority, or Jefferson Parish Human Services Authority (OCDD/CAHSD/MHSA/JPHSA) and for the Bureau of Community Supports and Services Mentally Retarded/Developmentally Disabled Request for Services Registry (BCSS MR/DD RFSR) provided they meet the criteria for a developmental disability after the age of 2 years, 6 months (2 ½)."

- If the child was determined eligible through the ChildNet system prior to July 1, 2003, the date of application for ChildNet will be the protected date for future OCDD/CAHSD/MHSA/JPHSA services and BCSS MR/DD RFSR provided they meet the criteria for a developmental disability after the age of 2 ½.

- Any referrals OCDD/CAHSD/MHSA/JPHSA gets from the EarlySteps Family Support Coordinator **(**FSC), which is where most referrals will come from, or the EarlySteps Systems Point of Entry (SPOE) Intake Coordinator for children who are eligible for and receiving specific Part C services through EarlySteps prior to the age of 2 ½ must include the following documentation:
  1. EarlySteps of Louisiana Individualized Family Service Plan
     a. *with "Section 7: Other Services" listing OCDD and the specific service OCDD will provide
  2. The Louisiana Department of Health and Hospitals Application for Services Children 0-3 with Special Needs (*listed as "Enrollment Form" on EarlySteps' website)*
  3. EarlySteps of Louisiana Reciprocal Consent to Release and Share Information
  4. EarlySteps of Louisana Eligibility Determination Documentation
  5. EarlySteps of Louisiana Eligibility Notification

- Any referrals OCDD/CAHSD/MHSA/JPHSA gets from the FSC or the SPOE Intake Coordinator for children who ARE eligible for but are NOT receiving specific Part C services through EarlySteps prior to the age of 2 ½ must include the following documentation:

  - The Louisiana Department of Health and Hospitals Application for Services Children 0-3 with Special Needs (*listed as "Enrollment Form" on EarlySteps' website)*
  - EarlySteps of Louisiana Reciprocal Consent to Release and Share Information
  - EarlySteps of Louisiana Eligibility Determination Documentation
  - EarlySteps of Louisiana Eligibility Notification

In these cases the OCDD/CAHSD/MHSA/JPHSA Support Coordinator or appropriate staff will do a Plan of Support for the child detailing the service the family is requesting. The OCDD/CAHSD/MHSA/JPHSA Office will send a copy of the OCDD/CAHSD/JPHSA Plan of Support to the appropriate EarlySteps FSC and SPOE Intake Coordinator.

*** The only exception to this is Cash Subsidy, where the protected date is the postmark date on the envelope.**

- If a family, a private FSC, or a SPOE Intake Coordinator refers a child to OCDD/CAHSD/MHSA/JPHSA *prior* to the age of 2 ½, who is eligible for participation in EarlySteps and has a completed IFSP without requesting specific OCDD/CAHSD/JPHSA services, refer the family to the appropriate SPOE; the private FSC to the appropriate SPOE; and clarify for the referring SPOE that families of children under 2 ½ must be requesting a specific service from OCDD/CAHSD/MHSA/JPHSA and the request must be in accord with the IFSP team's determination of needs.

- If a family brings a child who is 2 1/2 directly to OCDD/CHASD/MHSA/JPHSA *and* the family is requesting a place on the BCSS MR/DD RFSR, **OCDD should begin the process.** The OCDD Regional Office/CAHSD/MHSA/JPHSA must still refer the family to the appropriate SPOE.

- Children 2 years, 6 months s and older who have never received services through OCDD/CAHSD/MHSA/JPHSA, but have been determined eligible for participation in EarlySteps may be referred directly to OCDD/CAHSD/MHSA/JPHSA by the SPOE Intake Coordinator or the FSC to see if they meet the criteria for participation in OCDD/CAHSD/MHSA/JPHSA services and/or BCSS MR/DD RFSR. Our goal is for every child to have a determination from OCDD/CAHSD/MHSA/JPHSA by the age of 3.

- It is the responsibility of the FSC to send out a **Request for the Determination Process for System Entry to OCDD/CAHSD/MHSA/JPHSA** when the child reaches the age of 2 1/2 if the IFSP team determines the child may need further services.

Any family who requests a **Determination Process for System Entry** has the right to have one regardless of the IFSP team decision, and the FSC must refer the family to the proper OCDD/CAHSD/MHSA/JPHSA office.

Children's Special Health Services (CSHS):

EarlySteps Process for Referrals to Children's Special Health Services

Joint Application for Services (Louisiana Department of Health & Hospitals Application for Services Children 0 – 3 with Special Needs)

In order to support families in accessing other related systems of services, EarlySteps has created a joint application process with the Office for Citizens with Developmental Disabilities (OCDD), Medicaid and CSHS. For families of infants and toddlers in the EarlySteps system that are presumed eligible for CSHS and interested in applying for CSHS services, the EarlySteps application shall also serve as a referral and application to CSHS.

EarlySteps Referral Process to CSHS

During the application process or annual re-determination for children in EarlySteps, the System Point of Entry (SPOE) Intake Coordinator or Family Service Coordinator (FSC) must inform the families of children with a special health care need about the CSHS program.

SPOE/FSC Procedures for CSHS Referral

If a family of a child in the EarlySteps system is interested in being referred to CSHS and is presumed to meet CSHS medical eligibility requirements, the SPOE Intake Coordinator or FSC shall forward the following information to the CSHS Regional Office of residence:

1. "The Louisiana Department of Health and Hospitals Application for Services Children 0 – 3 with Special Needs"
2. EarlySteps Health Summary (if available) or EarlySteps Health and

Birth History Form. *One of these must accompany the Early Steps Application.*

3. Eligibility Determination Documentation

Note: For medical eligibility questions, call the Regional CSHS office.

Notification of CSHS Eligibility

CSHS staff will notify the SPOE and FSC (if appropriate) about the status of the child's eligibility for CSHS services. If child is not eligible for services, CSHS staff will indicate the reason the child is not eligible for services.

BCSS/MRDD Request for Services Registry: Use OCDD Process listed above

Louisiana Part C Early Intervention System Assessment Report Format

Section 1. Identifying Information:

Name of Child

Date of Birth

Chronological Age & Adjusted Age if applicable

Name of person conducting assessment:

Location where assessment was conducted:

Date when assessment was conducted:

Section 2. Reason for Referral to Part C

Purpose of Assessment: (Check one) ☐ eligibility determination ☐ IFSP development

Section 3. Background Information

Section 4. Questions to be answered through this assessment:

1.

2.

3.

4.

5.

Section 5. Child's strengths and developmental status in all domains (narrative)

Section 6. Information regarding function in the child's daily routines

Section 7. Summary and Recommendations (do not include specific services with frequency, intensity and method in the report)

Test /Assessment Report Instructions

1.Identifying information: Name, date of birth, date, chronological age/adjusted age , place of evaluation, evaluator(s).

2.Reason for referral: Record who made the referral to EarlySteps, the reason for the referral, and the areas of concern.

3.Background information: a. Developmental information – significant developmental information as reported by the family or referral source. **b. Health status based on review of pertinent records and medical history** – summarize pertinent records related to the child's health status and medical history. If records were not available, please note this. **c. Other tests and services** – note the type and dates of tests and services, which have been provided to the child. Report the services that have been provided to the family if they are related to enhancing the development of the child.

4. Questions to be addressed in the assessment: List the questions to be addressed during the test or assessment activity. **Example:** This (test or assessment) is being conducted to answer the following questions:

- Does _____ have a disability or developmental delay?
- What are _____'s current levels of development and daily routines?
- What are _____'s individual strengths and needs?
- What are the possible strategies for _____'s success in daily routines?
- What skills are _____ready to work on?

5.Discuss individual child strengths and developmental status

- In family friendly language, list the tool(s), if any, that were used and purpose of the tool
- Include information from informal assessments (checklists, criterion-referenced tools, etc.), clinical observation, and family members.
- Record observations and information from all members including the family and report what the child can do or what he is beginning to do.
- If the purpose of the report is to assist with eligibility determination, the information in this section should help identify if the child is a child with a disability or developmental delay and if he/she is eligible for Part C services. Typically, the section will contain scores. However, remember that scores should not stand-alone. Descriptive information should accompany scores.
- If the purpose of the report is assessment for IFSP planning/intervention planning, this section should contain information that will assist the IFSP team in developing outcomes. For example, the information should describe what the child is beginning to do, areas of need, and what strategies might be appropriate to target areas of need.

6.Information regarding daily routines, if obtained: This area may include additional information on the child's daily routines that was provided by the family during the intake activities or family assessment. This information should NOT be a duplication of information in the adaptive areas of the report.

7.Summary and recommendations: This section should summarize the information within the context of the report and discuss the child's strengths and needs. The report should indicate if early intervention services are needed. Specific recommendations related to frequency and intensity of services are not appropriate at this time and should not appear in this report. If the purpose of the activity was assessment for IFSP planning, the professional should provide strategies or activities that could be incorporated into the IFSP to support the process of developing child/family outcomes.

HEALTH SUMMARY

Please complete this form as this child's primary medical provider. Your participation is encouraged in order to ensure that appropriate medical information is available to assist in eligibility determination and service planning. If you have questions, please contact the Intake Coordinator named on the cover letter. Your signature below indicates the accuracy of the information provided. Thank you!

☐ Initial Health Summary ☐ Health Summary Update

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

MEDICAL INFORMATION (For Initial Health Summary Only)

Reason(s) for Referral: _____

Birth Weight: _____ _____ Gestational Age: _____Length of Hospital Stay: _____
grams lbs/oz

Complications, procedures: _____

Subsequent Hospitalizations/Surgeries: _____

CURRENT HEALTH STATUS (* Indicates data entered and stored electronically at the System Point of Entry)

Present concerns/diagnoses*/illnesses (Please indicate ICD 9 codes next to diagnoses):_____

Current Medications: _____

Medical Precautions/allergies: _____

Immunizations are up to date: __YES __NO Date you last saw this child: _____

Physical Status: _____

Vision: I (check one) _____ **have concerns** _ _____ **do not have concerns** about this child's vision. **Date screened:** _____ **Results:**_____
Comments: _____

Hearing: I (check one)_____ **have concerns** _____**do not have concerns** about this child's hearing. **Date screened:** _____ **Results:**_____
Comments:_____

Child's Name:_____

DEVELOPMENTAL STATUS: Please comment on each of these areas. If you have used a formal screening tool to assess these areas, please indicate below.

Adaptive skills:
Within normal limits for age: yes / no (circle one)
Atypical for age (Please explain):
Comments: _____
_____

Cognitive skills:
Within normal for age: yes / no (circle one)
Atypical for age (Please explain):
Comments: _____
_____

Motor skills:
Within normal for age: yes / no (circle one)
Atypical for age (Please explain):
Comments: _____
_____

Social and emotional skills:
Within normal for age: yes / no (circle one)
Atypical for age (Please explain):
Comments: _____
_____

Communication skills:
Within normal for age: yes / no (circle one)
Atypical for age (Please explain):
Comments: _____

Developmental screening test(s) completed:
Test(s) used:_____ Date:_____ Result:_____

Please attach any developmental screenings, assessments, subspecialty consults, or allied health assessments that may be helpful in determining this child's eligibility and/or early intervention needs.

Signature: _____ Date: _____ Name: _____
Primary Care Provider or Designated Representative
Address: _____Telephone: _____ FAX: _____Page 2 of 2

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Child's Health Information: EarlySteps is required to consider health information as part of the eligibility process. This helps the EarlySteps team to develop the whole developmental profile of your child.

Child's Name:_____ Date of Birth:_____

1.. Primary Care Physician Name		Date Last Seen
Address:		Telephone (____) _____-_____ FAX (____) _____-_____
2. Specialty Physician Name:	Specialty:	Date Last Seen
Address:		Telephone (____) _____-_____ FAX (____) _____-_____
3. Specialty Physician Name:	Specialty:	Date Last Seen:
Address:		Telephone (____) _____-_____ FAX (____) _____-_____

B. Are any of the following present?

- ☐ Parent, physician or provider has a concern about child's hearing
- ☐ Family history of permanent child hearing loss
- ☐ In-utero infections associated with hearing loss were present: bacterial meningitis, CMV, HERPES, Rubella, Syphilis, Toxoplasmosis (TORCH infection)
- ☐ Presence of a neurodegenerative syndrome
- ☐ Head Trauma
- ☐ Recurrent or persistent ear infections
- ☐ Syndrome known to include hearing loss or ear canal dysfunction (e.g., Down Syndrome)
- ☐ Infections after birth associated with sensorineural hearing loss including bacterial meningitis
- ☐ Medical conditions during the first month of life, including hyperbilirubinemia at a serum level requiring exchange transfusion, persistent pulmonary hypertension associated with mechanical ventilation, and conditions requiring the use of extracorporeal membrane oxygenation
- ☐ Syndromes associated with progressive hearing loss such as neurofibromatosis, osteopetrosis, and Ushers Syndrome
- ☐ Child is referred for speech or language delay or articulation issues

If any of the above is checked, child should be <u>screened</u> for hearing loss if a current (within three months) hearing screen is not available.

C. Are any of the following present?

- ☐ Parent, physician, or provider has concerns about child's vision
- ☐ Child presents with global developmental delay
- ☐ Child has a history of eye disease or dysfunction: cataracts, congenital glaucoma, nystagmus and has not been tested previously
- ☐ Child has a history of a TORCH infection in utero (see above)

If any of the above is checked, child should be <u>screened</u> for vision loss if a current (within three months) vision screen is not available.

D. Does your child currently use any adaptive equipment? (√ accordingly and complete)

	Wheelchair: Who provides/pays?		Walker: Who provides/pays?
	Splints/AFOs/Braces: Who provides/pays?		Eye Glasses: Who provides/pays?
	Adaptive Seating: Who provides/pays?		Hearing Aids: Who provides/pays?
	Adaptive Bathing: Who provides/pays?		Assistive Communication Device(s):Who provides/pays?
	Feeding Aids: Who provides/pays?		Other:
	Other:		Other:

E. Does your child use any of the following equipment? (Check as appropriate)

	Apnea Monitor		Feeding Tube		Other:
	Oxygen		Ventilator (dependent)		Other:

F.Does your child use any medications (specify type, route and purpose)?

Medication	Route (tube, mouth)	Purpose

G. Is your child on a special diet? Yes_____ No_____ If yes, Type_____

H. Does your child have any known allergies?
Yes_____ (specify _____) No_____

Notes:

2. Pregnancy, Birth and General Health History

Is there anything important about your pregnancy with your child, or his/her birth or early health history that will be helpful to us in determining your child's eligibility or in planning services together?

Date of Interview: _____

Information provided by: _____

Signature:_____

This form meets all applicable regulations for the Family Educational Rights and Privacy Act (FERPA) and the Health Information Privacy and Portability Act (HIPPA).

CONSENT TO RELEASE AND SHARE INFORMATION

I/We, _____,
Parent/Legal Guardian Name(s)

give my/our informed consent for: Early Steps, Louisiana's Early Intervention Services System to communicate and share information, in writing and conversation with:

_____
Individual Provider Name

_____
Agency (if applicable)

_____
Street Address/Post Office

_____
City/Town State Zip Code

Regarding:

_____
Child's Legal Name Date of Birth

_____
Street Address/Post Office

_____
City/Town State Zip Code

_____
Telephone

For the purpose of: (as checked)

_____ Access to the early intervention record (including obtaining copies required to determine eligibility), participate in service planning, and/or provide early intervention services as defined in the Individualized Family Service Plan (IFSP).
_____ Obtaining written specialty reports, including assessments
_____ Obtaining a copy of the Individualized Family Service Plan (IFSP)
_____ Obtaining progress reports
_____ Obtaining correspondence and other communications regarding eligibility and/or the provision of early intervention services
_____ Eligibility determination by OCDD
_____ Eligibility determination by the local education agency (LEA)
_____ Contact by the Community Outreach Specialist to discuss involvement in EarlySteps system activities
_____ Inclusion in mailings by the Community Outreach Specialist
_____ Participate in Transition Meeting
_____ Other: _____

I have read and understand the conditions of this release. This consent is valid for one year (12 months) unless I revoke it before the end of the year.

_____ _____
Signature (Parent/Legal Guardian/Educational Surrogate) Date

EARLY STEPS OF LOUISIANA
CONSENT TO RELEASE AND SHARE INFORMATION

PLEASE READ THIS CAREFULLY BEFORE SIGNING.
IF YOU HAVE QUESTIONS, PLEASE ASK YOUR INTAKE OR FAMILY SERVICE COORDINATOR.

The purpose of this release is to collect information necessary to determine my child's eligibility for the program listed above, and to plan and provide essential and necessary services as determined through the IFSP process. I hereby authorize the provider named on the reverse side of this form to release to the staff of Early Steps, Louisiana's Early Intervention System, upon presentation of this form, any records or information pertinent to the development and implementation of a plan for service to meet the developmental needs for the child named on this release.

I also give consent for the release of information by the Early Steps system to other individuals where an informed, written consent has been obtained from me; and to ensure ongoing service delivery in accordance with the IFSP through routine communications including report distribution, participation in IFSP meetings, and planning and review activities.

I understand that this consent includes the sharing of information as authorized above in written, verbal and/or video format. This consent is effective for a period up to twelve (12) months from the date of my signature on this release. As the parent/legal guardian or Early Steps Surrogate Parent, I understand that I may revise or revoke this release of information/consent to communicate at any point in time through the Intake/Family Service Coordinator indicated on the current IFSP.

The information collected as a result of this consent shall be maintained in my child's record, which will be located at the System Point of Entry for Early Steps, Louisiana's Early Intervention System. This record is subject to the provisions of the Family Educational Rights and Privacy Act (FERPA) and, as such, is available for my review and may be reproduced or corrected upon my request. All personal information collected will be treated as confidential.

Provider Selection Form
(Freedom of Choice)

The (check one) □ Intake Coordinator or □ Family Support Coordinator (FSC) showed me the EarlySteps Service Matrix (check format shown: □ Electronic or □ Hard Copy) and I selected the following early intervention providers for: (check appropriate activity)

- □ an assessment to determine eligibility OR
- □ an eligibility team meeting OR
- □ an IFSP development meeting OR
- □ the provision of early intervention services.

Name	**Specialty**

Parent Signature Date

Note: If chosen provider is not available, document by the provider's name the date provider declined the referral and initial it.

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Family Assessment of Concerns, Priorities and Resources

EarlySteps is designed to help families increase their abilities to enhance their child's growth and development. To do this, we need to find out what activities your family participates in and which of the activities are most problematic or concerning to you. EarlySteps uses this information to better understand your child's needs and what is most important to your family. This assessment of your concerns, priorities and resources is voluntary—that is, you can decide not to share this information with EarlySteps. We will continue to work with you and your child to determine eligibility.

Assessment of Family Concerns, Priorities, and Resources to enhance development of their child

Date completed: _____

Check appropriate box ☐ Family assessment completed with family concurrence.

☐ Family declined family assessment of concerns, priorities and resources (Parent signature)_____

This assessment is divided into four sections:

1. Family View of Child's Development—You will be asked to tell the Intake Coordinator or Family Support Coordinator what you think about your child's growth and development. While it is important to think about the whole child, you will be asked to talk about specific areas of your child's development. EarlySteps often calls these areas developmental domains
2. Family Activities—this section addresses those activities that your family frequently does. You will be asked to think about those activities that are most important to you and if you have any concerns with how your child participates in that activity. You may want to talk about activities that you would like to do but feel you can't because it's too hard or you fear that the activity would not be successful for your child.
3. Daily Living Routines—all children and families have similar routines of daily life. Daily life routines are things like sleeping or napping, eating, dressing, etc. You will be asked to think about the routines of your child's day—the routines may occur at home or in other settings like childcare, grandma's house, etc. We would like you to tell us if any of those routines are concerning to you.
4. Family Resources—EarlySteps is a partnership with families. Your family has resources that can be used to help with the interventions or strategies we decide to use with your child. Resources include people (like relatives, sisters and brothers, friends, church members, etc.), skills you or other family members have, or other things you feel help you.

The Intake Coordinator or Family Service Coordinator will ask you questions in each of the areas listed above. She will take notes on this form. The form has checkboxes to help fill it out quickly—the important part of the form are the boxes where your answer are written, Afterwards, the document will be shared with you so that you can be sure that your statements and thoughts were accurately captured. You will receive a copy of this completed document. Both you and the rest of the EarlySteps team will refer to the information on this document as they work with you during the eligibility determination. If your child is found eligible for EarlySteps, this information will be used as you and other members of the team develop the Individualized Family Service Plan. The FSC working with you will update this form on a regular basis so that the IFSP team has information about the changing needs of your child and family.

1. Family's View of Child's Development This section assists the Early Steps team to learn more about the child's development and your concerns about your child's growth and development. The information will help with the eligibility determination and, if your child is eligible for EarlySteps, the information will help establish priorities to address in the Individualized Family Service Plan.

What concern(s) does the family have about their child's development? (Discuss all developmental domains):

Physical:	1. Tell me about your child's ability to move:	Do you have a concern about this?
	2. Tell me about your child's growth:	Do you have a concern about this?
	3. Tell me about your child's ability to see:	Do you have a concern about this?
	4. Tell me about your child's ability to hear:	Do you have a concern about this?
Communication	Tell me how your child lets you know what he/she wants or needs:	Do you have a concern about this?

Social/Emotional	Tell me about how your child expresses happiness, sadness, frustration, and how he/she calms, etc.:	Do you have a concern about this?
Adaptive	Tell me how your child takes care of himself—feeding, sleeping, dressing self, etc.:	Do you have a concern about this?
Cognitive	Tell me how your child solves problems like getting a toy he/she wants:	Do you have a concern about this?

Is there anything you think we should know about your child's growth or development that we haven't talked about?

Part 2: Family Routines and Activities EarlySteps is designed to support you and your child with the routines and naturally occurring activities of daily life. The important routines and activities are the targets of any service you and your family receives in EarlySteps. All families have activities that they do on a frequent basis. Think about those activities that your family does and if any of them standout. Do you have any concerns with some of the activities that you do or are there barriers present that keep you from participating in the activity?

Activity	**What's happening now?**	**Area of development impacted by activity (check as needed)**
□ attending religious events □ visiting relatives or friends □ going to the library □ gardening or fitness activities □ attending siblings activities □ shopping □ family meals □ meal prep and clean up □ recreation (playing games, watching TV, listening to music, etc) □ other:	What is your child doing now during this activity? What can your child do by him or herself during this activity? How does your child get along with others during this activity?	_____Physical _____Cognitive _____Communication _____Social or Emotional _____Adaptive
Activity	**What's happening now?**	**Area of development impacted by activity**
□ attending religious events □ visiting relatives or friends □ going to the library □ gardening or fitness activities □ attending siblings activities □ shopping □ family meals □ meal prep and clean up □ recreation (playing games, watching TV, listening to music, etc) □ other:	What is your child doing now during this activity? What can your child do by him or herself during this activity? How does your child get along with others during this activity?	_____Physical _____Cognitive _____Communication _____Social or Emotional _____Adaptive

Activity	What's happening now?	Area of development impacted by activity
□ attending religious events □ visiting relatives or friends □ going to the library □ gardening or fitness activities □ attending siblings activities □ shopping □ family meals □ meal prep and clean up □ recreation (playing games, watching TV, listening to music, etc) □ other:	What is your child doing now during this activity? What can your child do by him or herself during this activity? How does your child get along with others during this activity?	____Physical ____Cognitive ____Communication ____Social or Emotional ____Adaptive
Activity	**What's happening now?**	**Area of development impacted by activity**
□ attending religious events □ visiting relatives or friends □ going to the library □ gardening or fitness activities □ attending siblings activities □ shopping □ family meals □ meal prep and clean up □ recreation (playing games, watching TV, listening to music, etc) □ other:	What is your child doing now during this activity? What can your child do by him or herself during this activity? How does your child get along with others during this activity?	____Physical ____Cognitive ____Communication ____Social or Emotional ____Adaptive

Part 3: Daily Living Routines Think about those routines that your child does everyday and if any of them standout. Do you have any concerns with some of the routines that you do or are there barriers present that keep your child from being successful?

Type of Routine	**What's your child doing during the routine?**	**Area of Development impacted by the activity**
Daily living Activities ☐ bathing ☐ dressing ☐ eating ☐ potty training ☐ playing indoors ☐ playing outdoors ☐ sleeping/napping	What is your child doing now during this activity? What can your child do by him or herself during this activity? How does your child get along with others during this activity?	_____ Physical _____Cognitive _____Communication _____Social or Emotional _____Adaptive
Type of Routine	**What's your child doing during the routine?**	**Area of Development impacted by the activity**
Daily living Activities ☐ bathing ☐ dressing ☐ eating ☐ potty training ☐ playing indoors ☐ playing outdoors ☐ sleeping/napping	What is your child doing now during this activity? What can your child do by him or herself during this activity? How does your child get along with others during this activity?	_____ Physical _____Cognitive _____Communication _____Social or Emotional _____Adaptive

Type of Routine	**What's your child doing during the routine?**	**Area of development impacted by the activity**
Daily living Activities ☐ bathing ☐ dressing ☐ eating ☐ potty training ☐ playing indoors ☐ playing outdoors ☐ sleeping/napping	What is your child doing now during this activity? What can your child do by him or herself during this activity? How does your child get along with others during this activity?	_____ Physical _____Cognitive _____Communication _____Social or Emotional _____Adaptive
Type of Routine	**What's your child doing during this routine?**	**Area of development impacted by the activity**
Daily living Activities ☐ bathing ☐ dressing ☐ eating ☐ potty training ☐ playing indoors ☐ playing outdoors ☐ sleeping/napping	What is your child doing now during this activity? What can your child do by him or herself during this activity? How does your child get along with others during this activity?	_____ Physical _____Cognitive _____Communication _____Social or Emotional _____Adaptive

Part 4: Family Resources All families have resources (people, skills, things) that help to support them. Sometimes others easily see the resources and sometimes the resource may be hidden within a person. Tell us about the resources you have to help you with your child.

Our family's priorities to address are:

This is the end of the Family Assessment of Concerns, Resources and Priorities. Thank you for your information and time.

Information provided by: _____ Signature:_____

Date: _____

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For SPOE use only

EARLYSTEPS TEAM MEETING ANNOUNCEMENT

Date:_____

Dear _____,
Parent's name

This is to confirm that a meeting has been scheduled for _____ at:
Child's name

Date: _____

Time: _____

Location: _____

The purpose of this meeting is (check one only):

____ to determine eligibility for EarlySteps services.

____ to develop the initial IFSP.

____ to plan transition to other services at age 3.

The following individuals have been invited to attend this meeting: (individuals are listed by name with discipline).

_____

_____

_____

We hope that you will share your observations, questions, concerns and priorities for your child and family during the meeting. You may also invite any additional individuals whom you would like to participate. If this time is not convenient or you need to reschedule for any reason, please contact me at_____.
(phone number) (address)

Sincerely,
Intake Service Coordinator
CC: All individuals listed above

April 2005

SPOE Checklist

Directions: Insert Date Activity was completed.

Intake Coordinator Name: _____SPOE:_____

Child's Name: _____Date of Birth:_____

Last First MM/DD/YYYY

Activity	Date Completed	Date Data Entered in SPOE Software	Steps for Activity Completion
Referral Form Received			Opened electronic records and hard copy; Data Entered
Initial Family Contact			Telephone or face-to-meeting
Acknowledgement to Referral			Letter mailed within 7 days of receipt of referral
Intake			Obtained Consent to Proceed for Eligibility & IFSP Development
			Administered ASQ (Data entry to be implemented at a later date)
			If needed, provided Notice of Action Refused: Eligibility Determination
			Completed LA DHH Application for Services; Data Entered
			Obtained signed Releases of Information
			Completed Birth & Health History Mailed Health Summary to child's medical home; Data Entered
			Completed Family Assessment of CPR
Eligibility			Service Matrix Form completed
			Authorizations for team meeting entered
			Eligibility Team Meeting Announcement sent
			Eligibility Consultant Statement completed
			Eligibility Determination Documentation Completed; Data Entered
IFSP Development			Service Matrix Form completed
			Authorizations for team or for assessments entered
			IFSP Team Meeting Announcement sent
			Completed IFSP; Data Entered
			Authorizations entered
			IFSP mailed to all team members
IFSP Revision			Receipt & processing of completed paperwork for early intervention record: Notification of appropriate IFSP team members Notice of Action provided to the family
			Completed IFSP Revision Form; Data Entered
			Completed Change of Authorization Form (as needed)
			IFSP Team Minutes

Activity	Date Completed	Date Data Entered in SPOE Software	Steps for Activity Completion
			For change of provider only, receipt and processing of Completed Parent Request to Change Provider Form
6-month Review			Receipt and processing of paperwork from FSC
			Notice of Action provided to the family
			Completed IFSP 6 Month Review Form, copy filed; Data Entered
			Completed Authorization Change Form; copy filed
			If needed, Authorizations entered
			Team Meeting Minutes (written, disseminated and filed)
Quarterly Report			Receipt and filing of Quarterly Report
Annual Re-determination of Eligibility			Receipt of completed paperwork from FSC; filed in early intervention record
			Notification of Eligibility Meeting to appropriate IFSP team members
			Notice of Action provided to the family
			Completed Eligibility Documentation; Data Entered
			Team Meeting Minutes
Annual IFSP			Receipt of completed paperwork from FSC; filed in early intervention record
			Service Matrix Form completed, if needed
			Authorizations for team or for assessments entered
			IFSP Team Meeting Announcement
			Completed IFSP; Data Entered
			Authorizations entered
Transition			Receipt of completed paperwork from FSC; filed in early intervention record
			Transition Letter sent to LEA (must be no earlier than child's age of 2.2 and no later than child's age of 2.6)
			Notification of appropriate IFSP team members
			Notice of Action provided to the family
			Team Meeting Minutes (written, disseminated, and filed)
			Signed and dated Releases of Information (as needed)
			OCDD/BCSSSR Letter of Notification
			Date information sent to receiving program per parent's written consent
Case Closure			Completed Case Closure Form; Data Entered
			Copies of any needed correspondence

Activity	Date Completed	Date Data Entered in SPOE Software	Steps for Activity Completion
			Date copies of early intervention record sent per parent's written consent
Miscellaneous forms			Receipt of completed paperwork from FSC; filed in early intervention record

Eligibility

Request for Authorization

Note: This request form is used only by Intake and Family Service Coordinators

Section 1.

Date:_____ Parish_____

Child's Name:_____ D.O.B. _____

Section 2. Provider Information:

Billing Entity (Please Complete) Service Provider

Name: _____ Address: _____ _____ City:_____ State:_____ Zip:_____ Tel: _____	Name: _____ Address: _____ _____ City:_____ State:_____ Zip:_____ Tel: _____
Specialty	*Location*

Section 3. Authorization Information

Start Date of Service_____ Estimated Length of Request __30 Days __ 60 Days

Number of Minutes needed: (Not to exceed 150 minutes) _____

☐ IFSP Team Meeting ☐ Eligibility Team Meeting

☐ Transition Team Meeting ☐ Assessment

Requested by:_____ Date: _____

Data Entry by:_____ Date: _____

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EarlySteps Eligibility Consultant Statement

Section 1. Identifying Information

Name of Child_____ Date of Birth_____

Chronological Age & Adjusted Age if applicable:_____

Name and title of person providing input:
_____

Section 2. Statement of Informed Clinical Opinion

I have reviewed the intake packet sent to me by the Intake Coordinator. Based upon the information and my knowledge of child development, this child has a

☐ Developmental delay in the developmental domain of _____

OR

☐ Medical condition that results in a developmental delay or developmental disability

(diagnosis)_____ IC9 Code:_____

OR

☐ This child does not have a developmental delay or medical condition that results in a developmental delay or developmental disability.

Additional comments or observations:

Signed: _____ Date:_____

ELIGIBILITY DETERMINATION

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Check one:
Initial Eligibility □
Annual Eligibility □

SPOE:_____ Date: _____

*Intake Coordinator/Family Service Coordinator: _____

*Child's Name: _____*Date of Birth:_____ Age/Adjusted Age:_____

* Parent/Guardian Name: _____ *Date of Referral: _____

Section A. Statement of Eligibility **Eligibility determination activities pursuant to 34 CFR 303.300 and 303.322 were conducted for this child and resulted in the findings as stated below.**

1. Child is determined eligible based upon: (check appropriate methodology used)

□ Informed Clinical Opinion (attach page 2A) **OR** □ Formal Testing or Assessment (attach page 2B)

Check eligibility criteria met:

_____*Documentation of diagnosed medical condition that results in a developmental delay or developmental disability

Diagnosis: _____ *Primary ICD-9 Code:_____

*Secondary ICD-9 Code:_____

OR

_____*Documentation of developmental delay in the domain(s) of : _____

*Primary ICD-9 Code:_____

OR

2. Child is determined **NOT** eligible.

Referral(s) made to:_____ Date: _____

Procedural Safeguards (Parents Rights) were reviewed: ___yes ___no, if no, why not:_____

Eligibility Team

Name	Title	Method of Participation
		□ Attended meeting □ Report □ Telephone □ Representative attended
		□ Attended meeting □ Report □ Telephone □ Representative attended
		□ Attended meeting □ Report □ Telephone □ Representative attended

ATTACH APPROPRIATE DOCUMENTATION TO THIS PAGE

Use this page to record the eligibility team's discussion and application of eligibility criteria.

1. What was the reason for referral?	Does this meet or support the eligibility criteria? ☐ Yes-- If so, how: ☐ No
2. What is the family's statement of concerns about their child's development?	Does this meet or support the eligibility criteria? ☐ Yes-- If so, how: ☐ No
3. Screening Information Vision: ☐ no concerns ☐ needs further assessment Hearing: ☐ no concerns ☐ needs further assessment Development (ASQ results) Communication: ☐ no need for further assessment ☐ needs further assessment Gross Motor ☐ no need for further assessment ☐ needs further assessment Fine Motor ☐ no need for further assessment ☐ needs further assessment Problem-Solving ☐ no need for further assessment ☐ needs further assessment Personal-social ☐ no need for further assessment ☐ needs further assessment	Does this meet or support the eligibility criteria? ☐ Yes-- If so, how: ☐ No
4. Pertinent Health/Medical information a. Child has a medical home: ☐ yes ☐ no b. Immunizations are current: ☐ yes ☐ no c. Child receives regular well-child health services: ☐ yes ☐ no --Is this through a medical home? ☐ yes ☐ no --Has medical home noted concerns with Hearing: ☐ yes ☐ no Vision: ☐ yes ☐ no Development: ☐ yes ☐ no Are there health or medical issues, which impact this child that are associated with developmental delay or developmental disabilities? _____ _____	Does this meet or support the eligibility criteria? ☐ Yes-- If so, how: _____ _____ _____ _____ _____ _____ ☐ No
5. Other existing information:	

Attach any supporting documents that the team feels is helpful. Attach completed form to cover page, entitled: Eligibility Determination

Team Statement of Formal Testing or Assessment Information

Use this page to record the team's discussion and application of eligibility criteria.

Domain	Statement of Child's level of performance, including age equivalency if needed for clarity and understanding of level of performance. Statements should identify skills and abilities.
Thinking and learning (cognition) Date: Instrument(s) Used:	Clinician's Name:
Moving, seeing, hearing (physical development) Date: Instrument(s) Used:	Clinician's Name:
Understanding and communicating (communication) Date: Instrument (s) Used:	Clinician's Name:
Getting along with others (social/emotional/behavior) Date: Instrument (s) Used:	Clinician's Name:
Doing things for him/herself (adaptive development) Date: Instrument Used:	Clinician's Name:

Verification of Assessment Procedures: Check appropriate response

Conducted in the family's native language or mode of communication? ☐ Yes ☐ No: explain _____

Conducted in the child's native language or mode of communication? ☐ Yes ☐ No: explain_____

Attach any supporting documents that the team feels is helpful. Attach completed form to cover page, entitled: Eligibility Determination

IFSP

INDIVIDUALIZED FAMILY SERVICE PLAN

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Section 1. Child Information

***Child's name:**_____ ***Nickname:** _____ ***Gender:** (circle one) M F

***Home Address:**_____ ***Mailing Address:**_____

***City/Town:** _____**LA** ***Zip Code:**_____ ***Parish:**_____

***Date of Birth:** ***Current Age/Adjusted Age:** **Today's Date:**

Section 1A. General Contact Information

***Parent/Guardian:**_____

***Relationship to Child:** _____

***Address:**

_____

_____

***Telephone:**

Home_(____)_____ **Work_(____)_____**

Cell_(___)_____ **Best time to call:_____**

***Native Language Used:**_____

***Other contact person**

***Name:**_____

***Relationship:** _____

Section 1B. IFSP History and Family Support Coordinator (FSC)

FSC: _____
name

Telephone: _____

IFSP History

Date of Initial IFSP meeting: _____

Projected Date of Annual IFSP: _____

Type of IFSP and Date:

- ☐ **Interim** _____
- ☐ **6 month Review** _____
- ☐ **Initial** _____
- ☐ **Transition** _____
- ☐ **Annual** _____
- ☐ **Review/Revision** _____

Notice of Action—IFSP Development: The IFSP is the documentation of a team discussion. The IFSP reflects the strategies and services needed to support the achievement of the outcomes identified by the team. We are proposing to implement this plan of early intervention services that have been individualized to meet the needs of child and family listed above. The family has received a copy of the Parent's Rights.

*Indicates information to be entered and stored electronically at the System Point of Entry

Early Steps of Louisiana IFSP

Child's name:_____ Date of Birth:_____ Date of IFSP: _____
Last/first/middle mm/dd/vvvv mm/dd/vvvv

Section 2: Present Level of Functioning/Development.

Moving:
Thinking/Learning:
Understanding and communicating:
Getting along with others:
Doing things for him or herself:
Current health status:
Vision recently checked; results:
Hearing recently checked; results:

Child's name:_____ Date of Birth:_____ Date of IFSP: _____
last/first/middle mm/dd/yyyy mm/dd/yyyy

Section 3. Summary of Family Concerns, Priorities, and Resources to enhance the development of their child

Date completed: _____

Check appropriate box: ☐ Family assessment completed with family concurrence.

☐ Family declined family assessment of concerns, priorities and resources (Parent signature)_____

We have concerns about the routines and activities listed below. Please review the Family Assessment of CPR for details.

Section 4. Priorities of the Family (should be selected from items checked in Section 3 and reflected as an outcome in Section 6)

Strengths, resources that our family has to help meet our child's needs:

Child's name:_____Date of Birth:_____ Date of IFSP:_____
last/first/ middle mm/dd/yyyy mm/dd/yyyy

Section 5 Transition Planning Checklist

✓ item	Transition into and within EarlySteps	Specific transition issues	Responsible individual
	Transition from hospital or neonatal intensive care unit to home and into early intervention services to ensure no disruption of necessary services		
	Family related changes that may affect the IFSP service delivery (i.e., employment, birth or adoption of sibling, medical needs of other family members)		
	Child related changes that may affect the IFSP service delivery (i.e., hospitalization, surgery, placement in a child care setting, addition of new equipment or technology, medication changes)		
	Introduction of new or a change in: Service provider Service location		
	Termination of existing IFSP service		
	Explore community program options for our: Child Family		
	Child and family exiting from Part C system due to: Loss of eligibility Family does not agree to participate Child and family achieved all outcomes		
Transition from Part C: Required elements to be completed no earlier than 6 months prior to the child's third birthday and no later than 90 days prior to the child's third birthday. Elements checked are required at each IFSP meeting.			
✓	Discussions with, and training of parents regarding future placements and other matters related to the child's transition		
✓	Discussions about procedures to prepare the child for changes in service delivery including steps to help the child adjust and function in a new setting		
	With parental consent, send information about the child to the local educational agency to ensure continuity of services including assessment of information and current IFSP		
	With parental consent, send specified information to community programs to facilitate service delivery or transition from the Part C early intervention system.		

Child's name:_____ Date of Birth:_____ Date of IFSP:_____
last / first/ middle mm/dd/yyyy mm/dd/yyyy

Section 6. Family and child centered outcome (s) (Desired outcome #_____) This page should be duplicated as needed; bolded items are required by state and federal rules.

Outcome:	What's happening now?

What do we want this child and/or family to accomplish in the next 6-12 months? (timeline) (3 & 6 month required; 9 & 12 optional)

In the next:
- ☐ 3 months, we want to see: _____
- ☐ 6 months, we want to see: _____
- ☐ 9 months, we want to see: _____
- ☐ 12 months, we want to see: _____

What strategies will the family use in their daily routines and activities to support the outcome?

With whom and where can these strategies be practiced?

Procedure for measuring progress towards this outcome:

Criteria for measuring progress: Our team will be satisfied that we are finished with this outcome when:

Child's name:_____ Date of Birth:_____ Date of IFSP: _____
Last/ first /middle mm/dd/vvvv mm/dd/vvvv

Section 7 *Early Intervention Resources, Supports and Services *This entire page is part of the electronic record. NOTE: Attach Page 6A if providing Assistive Technology Devices or Services and Transportation Services

Column A	B	C	D	E	F	G	H		I	J Provider's Name/Payee Type
Early Intervention Service	Outcome Number	Location Code	Frequency	Intensity	Start Date	End Date	Method	Check □ Ind □ Group	Funding Source	□ Indpt □ Agency
								□ Ind □ Group		□ Indpt □ Agency
								□ Ind □ Group		□ Indpt □ Agency
								□ Ind □ Group		□ Indpt □ Agency
								□ Ind □ Group		□ Indpt □ Agency
								□ Ind □ Group		□ Indpt □ Agency
								□ Ind □ Group		□ Indpt □ Agency

K. Consider all services identified on this IFSP. What is the Primary Setting for this IFSP (circle)?

a. special purpose facility **b**. community setting **c**. home **d**. hospital **e**. residential facility **f**. service provider setting **g**. other setting

The contents of this completed IFSP have been fully explained to me/us. I /we give informed, written consent to implement the services described in the section of the IFSP. I/we have received a written copy of our Parents Rights within the Early Steps Early Intervention System.

_____

Parent/Guardian/ Foster Parent or Surrogate Signature Date

**LEGEND:

Column C, Location Code: 1 = home and/or community setting 5 = special purpose center with inclusive child care 6 = special purpose center or clinic
Column H, Method Code: 1= Early Intervention Service 2= Family Education Training Support 3 = Assessment
Column I, Funding Codes: A: CFO B: Private Insurance C: MFP funds D: Other State Funds

Child's name:_____ Date of Birth:_____Date of IFSP_____
Last /first /middle mm/dd/yyyy mm/dd/yyyy

Section 7 Continued (complete this page if needed). *Assistive Technology Device * Indicates information entered and stored electronically

IFSP Outcome #	*Name of Device	Vendor Providing Device	*Where is device used?	*When is device used?	*Start Date	*End Date	*HCPCS Code	*Price/Cost
							Total cost for all assistive devices listed:	

Section 7 Continued: *Transportation

IFSP Outcome #	*Start Date	*End Date	*Provider	*Frequency	*Maximum miles per trip; expressed as round trip

Child's name:_____ Date of Birth:_____ Date of IFSP_____

Last/first/middle mm/dd/yyyy mm/dd/yyyy

Section 8. Other Services (required section)

Service	Family or Child Service (circle)	Responsible Person Contact Information	Funding Source or steps to secure service
Primary Medical Home or Physician	Family child		
	Family child		
	Family child		
	Family child		
	Family child		
	Family child		

Section 9 IFSP Development Team and Contributors

Printed Name	Position/Role	Agency (if applicable)	Telephone	Signature or Method of Participation

Child's name:_____ Date of Birth:_____ Date of IFSP:_____
Last/first/middle mm/dd/yyyy mm/dd/yyyy

Section 1O: Justification for Early Intervention Services Delivered outside of Child's Natural Environments
Complete as needed. The provision of early intervention services for any infant or toddler occurs in a setting other than a natural environment only when the early intervention (outcomes) cannot be achieved satisfactorily for the infant or toddler in a natural environment. **Each service provided outside of the natural environment must have a justification; attach an individual justification needed to document each service.**

Outcome #: _____ Early Intervention Service: _____

Explain how and why the IFSP team determined that the outcomes could not be achieved in the child's natural environment.	How will services provided in this location be generalized to support the child's ability to function in his or her natural environment?	Develop a plan with timelines and identify the supports necessary to allow the child's outcomes to be satisfactorily achieved in the child's natural environments.

Comments:

IFSP 6-month Review

Child's name:_____ Date of Birth: _____ Parish of Residence:_____
Last/First/MI mm/dd/yyyy

IFSP Review Date:_____ **FSC:**_____**Telephone:** _____
Mm/dd/yyyy

Outcome (write this out in words)	What is child or family doing now that they weren't doing 6 months ago?	How do we rate this progress?	What action do we need to do now?**
		__ Outcome achieved __ Outcome partially obtained __Need to keep working on this Comment:	___Celebrate the progress! ___Keep doing what we are doing ___ Revise the early intervention services but keep same outcome □ Any increase in early intervention services are based upon lack of progress or regression ___ Revise both the outcome and the services
		__Outcome achieved __ Outcome partially obtained __Need to keep working on this Comment:	___Celebrate the progress! ___Keep doing what we are doing ___ Revise the early intervention services but keep same outcome □ Any increase in early intervention services are based upon lack of progress or regression ___ Revise both the outcome and the services
		__Outcome achieved __ Outcome partially obtained __Need to keep working on this Comment:	___Celebrate the progress! ___Keep doing what we are doing ___ Revise the early intervention services but keep same outcome □ Any increase in early intervention services are based upon lack of progress or regression ___ Revise both the outcome and the services

Note: FSC services must be added at the 6-month review; proceed to next page of form.

6-Month Review: IFSP Revisions

Child's Name: _____DOB: _____Date of Meeting:_____

Directions: Complete all sections of this form. Documentation must clearly describe that the parent was provided a written Notice of Action: IFSP Revisions and that a simultaneous team discussion identified the need for change.

1. Concern and rationale for change:

2. If changes involve increasing adding a service or increasing the frequency and/or intensity of early intervention services, there is objective documentation of lack of progress or regression and identification of all strategies used to address lack of progress or regression. Data/Documentation used to support decisions:

Parent: I participated in the team meeting concerning this change in early intervention services. I give consent to implement the service revisions as described in this document. I have received a written copy of Parents Rights in EarlySteps. _____

Signature Date

FSC: _____

Signature Agency

Early Intervention Provider(s) Signature: _____

_____

_____

Check appropriate action below. Follow any additional steps as indicated by the item checked.

____ Adding an early intervention service; FSC services must be added at a 6-month review. This action requires that an Authorization Change Form be completed and submitted to the SPOE; parents must receive a Notice of Action: IFSP Revisions. Proceed to next page of form.

____ Change in frequency of service is needed. This action requires that an Authorization Change Form be completed and submitted to the SPOE; parents must receive a Notice of Action: IFSP Revisions.

____ Change in intensity of service (length of time for each session) is needed. This action requires that an Authorization Change Form be completed and submitted to the SPOE; parents must receive a Notice of Action: IFSP Revisions.

____ Change in location of service is required. This change requires an Authorization Change Form be completed. An IFSP natural environments justification must be completed and submitted to the SPOE along with the Authorization Change Form; parents must receive a Notice of Action: IFSP Revisions.

____ Team determined that there is no need for change to the IFSP or early intervention services. No additional paperwork is required.

6-Month Review: IFSP Revisions

Child's Name: _____ DOB: _____Date of Meeting:_____

Complete the table below to indicate the changes needed to authorizations. The current authorization will be cancelled and a new authorization with the changed information will be issued. Early Intervention Service Revisions—

Legend	Early Intervention Service	Outcome Number	Location Code	Frequency	Intensity	Start Date	End Date	Method		Fund	Provider's Name/Payee Type
Current Service								☐	Ind		☐ Independent ☐ Agency
								☐	Group		
+	**FSC**							☐	Ind		☐ Independent ☐ Agency
								☐	Group		
								☐	Ind		☐ Independent ☐ Agency
								☐	Group		
								☐	Ind		☐ Independent ☐ Agency
								☐	Group		
								☐	Ind		☐ Independent ☐ Agency
								☐	Group		

Legend: Current Service Detail to Modify + = Addition of a service - = Termination/Elimination of Service

Location Code: 1 =home or community setting 5=special purpose center or clinic 6 =special purpose center with inclusive child care
Method Code: 1= Early Intervention Service 2= Family Education Training Support 3 = Assessment
Fund Code: A= CFO B= Private Insurance C=MFP D=Other State Funds

Submitted by:_____ Telephone: _____

IFSP REVISION (not associated with a 6 month review)

Child's name: _____ Date of Birth:_____

FSC: _____ Date of Meeting: _____

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Directions: Complete all sections of this form if the team discussion occurs before a 6-Month Review or Annual IFSP. Documentation must clearly describe that the parent was provided a written Notice of Action and that a simultaneous team discussion identified the need for change.

1. Concern and rationale for change:

2. If changes involve increasing adding a service or increasing the frequency and/or intensity of early intervention services, there is objective documentation of lack of progress or regression and identification of all strategies used to address lack of progress or regression. Data/Documentation used to support decisions:

Signatures of Team Members who discussed the need for change:

Parent: I participated in the team meeting concerning this change in early intervention services. I give consent to implement the service revisions as described in this document. I have received a written copy of Parents Rights in EarlySteps. _____

Parent Signature

Date

FSC: _____

Signature

Agency

Early Intervention Provider(s) Signature: _____

Check appropriate action below. Follow any additional steps as indicated by the item checked.

____ Change in frequency of service is needed. This action requires that an Authorization Change Form be completed and submitted to the SPOE; parents must receive a Notice of Action: IFSP Revisions.

____ Change in intensity of service (length of time for each session) is needed. This action requires that an Authorization Change Form be completed and submitted to the SPOE; parents must receive a Notice of Action: IFSP Revisions.

____ Change in location of service is required. This change requires an Authorization Change Form be completed. An IFSP natural environments justification must be completed and submitted to the SPOE along with the Authorization Change Form; parents must receive a Notice of Action: IFSP Revisions.

____ Team determined that there is no need for change to the IFSP or early intervention services.

IFSP Revision: IFSP Authorization Change Form

Child's name:_____ **Date of Birth:**_____ **IFSP Review Date:**_____
last/first/m iddle mm/dd/yyyy mm/dd/yyyy

Parish of Residence:_____ **Effective Date of Change:**_____
mm/dd/yyyy

FSC: _____ **Telephone number:** _____

Complete the table below to indicate the changes needed to authorizations. The current authorization will be cancelled and a new authorization with the changed information will be issued.

Early Intervention Service Revisions—BILLING PURPOSES ONLY

Legend	Early Intervention Service	Outcome Number	Location Code	Frequency	Intensity	Start Date	End Date	Method		Fund	Provider's Name/Payee Type	
Current Service								☐ ☐	Ind Group		☐ ☐	Independent Agency
+	**FSC**							☐ ☐	Ind Group		☐ ☐	Independent Agency
								☐ ☐	Ind Group		☐ ☐	Independent Agency
								☐ ☐	Ind Group		☐ ☐	Independent Agency

Legend: Current Service Detail to Modify + = Addition of a service - = Termination/Elimination of Service
Location Code: 1 =home or community setting 5=special purpose center or clinic 6=special purpose center with inclusive child care
Method Code: 1= Early Intervention Service 2= Family Education Training Support 3 = Assessment
Fund Code: A= CFO B= Private Insurance C=MFP D=Other State Funds

Submitted by _____Telephone: _____

FSC use only

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NOTICE OF ACTION: Re-Determination of Eligibility

Date Notice Provided to Family: _____

Notice of Action: The EarlySteps system ☐ proposes or ☐ refuses to determine my child's continuing eligibility (Re-determination of eligibility).

Reason: (check one that applies)
☐ Child appears to continue to have developmental delays or a developmental disability.

☐ Child is functioning at age appropriate developmental levels and no longer needs early intervention as evidenced by ongoing assessment information.

I understand that I have certain rights, opportunities and responsibilities that apply to my family's participation in Early Steps, Louisiana's Early Intervention Service System.
My rights, opportunities and responsibilities were explained to me, both verbally and in writing. I received my Parents Rights, which describes the rights, opportunities, and responsibilities available to me. I understand that the early intervention providers will follow procedures to assure that my rights and those of my child are guaranteed. This document includes information regarding:

(1) Evaluation for Eligibility Determination, and Assessment Service(s) for eligibility determination and/or IFSP development,
(2) Six Month Review and Annual Evaluation of the IFSP,
(3) Confidentiality of Information,
(4) Procedures for filing complaints; and
(5) Mediation and Due Process Hearings.

I understand that the proposed actions checked above are a result of a team meeting. I also understand that EarlySteps must wait at least three (3) calendar days before taking any of the above listed actions. If I do not agree with the proposed changes, I can contact the FSC listed below who will assist me in requesting a due process hearing to challenge the team's decisions.

Child's Name:_____

_____

Family Support Coordinator (FSC) Date

Telephone:_____

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NOTICE OF ACTION: IFSP REVISIONS

Date Notice Provided to Family: _____

Notice of Action: EarlySteps ☐ proposes or ☐ refuses to:

☐ Revise my child's IFSP:

- ☐ **Increase** the intensity or frequency of early intervention services
  Reason:
  - ☐ Child is not making satisfactory progress as evidenced by ongoing assessment
- ☐ **Decrease** the intensity or frequency of early intervention services
  Reason:
  - ☐ Child has made obtained outcome
  - ☐ Child has made enough progress to decrease intensity and/or frequency to a lower level
  - ☐ Child is not responding to the frequency or intensity due to over stimulation, fatigue, etc.
  - ☐ Parent requests a decrease in amount of service

☐ Change the method of service delivery of early intervention services due to child's need for group or individual (circle appropriate change) teaching (instruction)

☐ Terminate (end) an early intervention service
Reason:

- ☐ Child's or family's achievement of the outcome
- ☐ Specific early intervention service is no longer needed (Specify service: _____)

I understand that I have certain rights, opportunities and responsibilities that apply to my family's participation in Early Steps, Louisiana's Early Intervention Service System. My rights, opportunities and responsibilities were explained to me, both verbally and in writing. I received booklet (Parents Rights), which describes the rights, opportunities, and responsibilities available to me. I understand that the early intervention providers will follow procedures to assure that my rights and those of my child are guaranteed.

I also understand that EarlySteps must wait at least three (3) calendar days before taking any of the above listed actions. If I do not agree with the proposed changes, I can contact the FSC listed below who will assist me in requesting a due process hearing to challenge the team's decisions.

Child's Name: _____

_____ _____

Family Support Coordinator (FSC) Date

Telephone:_____

Request for Authorization

Note: This request form is used only by Intake and Family Service Coordinators

Section 1.

Date:_____ Parish_____

Child's Name:_____ D.O.B. _____

Section 2. Provider Information:

Billing Entity (Please Complete) Service Provider

Name: _____ Address:_____ _____ City:_____ State:_____ Zip:_____ Tel: _____	Name: _____ Address:_____ _____ City:_____State:_____ Zip:_____ Tel: _____
Specialty	*Location*

Section 3. Authorization Information

Start Date of Service_____

Estimated Length of Request __30 Days __ 60 Days

Number of Minutes needed: Not to exceed 150 minutes _____

☐ IFSP Team Meeting ☐ Eligibility Team Meeting

☐ Transition Team Meeting ☐ Assessment

Requested by:_____ Date: _____

Data Entry by:_____ Date: _____

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EarlySteps Eligibility Information for OCDD or BCSS Referrals

Date:_____

Child's Name:_____ Parent's Name:_____

This is to confirm that your child _____ is requesting services from the Office of Citizens with Developmental Disabilities (OCDD) and/or The Bureau of Community Supports and Services (BCSS):

☐ **Eligible for EarlySteps,** Part C of the Individuals with Disabilities Education Act Early Intervention System

Date of Intake: _____

Date of Eligibility Determination:_____

*Diagnosis:*_____ *Primary ICD-9 Code:*_____

or

Documentation of developmental delay in the domain(s) of _____

_____

Primary ICD-9 Code:_____ Secondary ICD-9 Code:_____

☐ **Ineligible for EarlySteps,** Part C of the Individuals with Disabilities Education Act Early Intervention System

Date of Eligibility Determination:_____

This eligibility determination was conducted in accordance with the regulations of Part C of the IDEA. There are specific rights that are associated with the determination of eligibility that are listed in the Parents Rights document that you have received. Please refer to the Parents Rights section on Due Process if you do not agree with your child's eligibility determination.

Enclosed are copies of the following documents for the OCDD or BCSS records:

- Enrollment Application (DHH Application for Services)
- Consent to Proceed
- Reciprocal Release of Information
- Family Assessment of Child's Development
- Eligibility Determination Documentation; and if your child is eligible,
- IFSP

Intake or Family Service Coordinator: _____

Telephone Number:_____

FAMILY SERVICE COORDINATOR QUARTERLY PROGRESS REPORT

FORM AND INSTRUCTIONS

Complete form according to the following schedule:

Due Date to SPOE	Report Period
October 15	July 1-September 30
January 15	October 1-December 31
April 15	January 1-March 30
July 15	April 1-June 30

Each outcome must be reported on separately with all services supporting that outcome addressed.

Disposition of Form:
Original FSC Quarterly Summary—send to SPOE for inclusion in child's early intervention record
Copy 1—send to family
Copy 2—maintain in FSC clinical file
Additional copies may be sent to IFSP team members or other parties (such as primary care physician). Written parental consent is required for sharing with anyone other than IFSP team members.

EARLY STEPS OF LOUISIANA QUARTERLY PROGRESS REPORTS

Child's Name:	DOB:	Date:
Address:	Family Service Coordinator (FSC):	
Parent/Guardian:	FSC phone number:	

Quarterly Progress Towards Outcome(s):

Outcome #	Progress Summary: what is the child doing differently now than before?	Eval Scale*	Name of Provider and Service Type
Family Changes that impact development			
Other Significant Changes			

*Evaluation Scale: 1=Situation changed; outcome not needed, 2=Situation unchanged; still need outcome, 3=Outcome partially attained, 4=Outcome Accomplished

_____

Family Service Coordinator Signature DATE

For FSC use only

EarlySteps Team Meeting Announcement

Date:_____

Dear _____,
Parent's name

This is to confirm that a meeting has been scheduled for _____ at:
Child's name

Date: _____

Time: _____

Location: _____

The purpose of this meeting is:

____ to discuss continuing eligibility for Part C services.
____ to review/revise the IFSP.
____ to hold the annual IFSP meeting.
____ to hold a transition meeting.

The following individuals have been invited to attend this meeting: (individuals are listed by name with discipline).

_____

_____

_____

We hope that you will share your observations, questions, concerns and priorities for your child and family during the meeting. You may also invite any additional individuals whom you would like to participate. If this time is not convenient or you need to reschedule for any reason, please contact me at_____.
(phone number) (address)

Sincerely,

Family Service Coordinator

CC: All individuals listed above

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Parent Request to Change Provider

Child's name: _____Date of Birth:_____

I want to select a different early intervention provider to work with my family and child. I understand that this is a choice that I have the right to make and can change providers whenever I feel it's necessary without jeopardizing the early intervention services that my child and family are receiving.

I would like to select a different (check one):

_____ Family Support Coordinator (FSC) from the same agency as the current FSC
Name of new FSC: _____

_____ Family Support Coordinator (FSC) from a different service coordination agency
Name of new FSC: _____

_____Early Intervention Provider: (Check one)
Name of new Provider:_____

Type of provider (check one)

- ☐ **Audiology Provider**
- ☐ **Health Services Provider**
- ☐ **Interpreter services (bilingual) Provider**
- ☐ **Interpreter services (sign) Provider**
- ☐ **Medical Services Provider**
- ☐ **Nursing Services Provider**
- ☐ **Nutrition Services Provider**
- ☐ **Occupational Therapy Provider**
- ☐ **Physical Therapy Provider**
- ☐ **Psychology Services Provider**
- ☐ **Social Work/Counseling Services Provider**
- ☐ **Special Instruction Provider**
- ☐ **Speech Language Pathology Provider**
- ☐ **Vision Services Provider**
- ☐ **Transportation Provider**

Effective Date for Change:_____

Signature of Parent:_____

Date: _____

For SPOE Use Only:
Date Copy Sent to Both Providers:_____
Date Original Filed in Early Intervention Record:_____

Provider Selection Form
(Freedom of Choice)

The (check one) □ Intake Coordinator or □ Family Support Coordinator (FSC) showed me the EarlySteps Service Matrix (check format shown: □ Electronic or □ Hard Copy) and I selected the following early intervention providers for: (check appropriate activity)

- □ an assessment to determine eligibility OR
- □ an eligibility team meeting OR
- □ an IFSP development meeting OR
- □ the provision of early intervention services.

Name	**Specialty**

Parent Signature Date

Monthly Progress Report

Directions: Complete this form with the parent/caregiver and send the original to the Family Service Coordinator designated for the child. Keep a copy for your records and send a copy to the parent/caregiver. This form is due to the Family Support Coordinator by the tenth day of the following month.

Provider name: _____ Child's Name: _____

Provider billing address: _____ Telephone: _____

Month reporting on: _____ How often were early intervention services provided this month?_____

What is the child or family doing now that he/she/they wasn't doing before? (Note outcome and describe progress, new skills, etc. without using technical terms or medical terminology).

Outcome	Comments

Please rate progress toward achieving the IFSP outcomes you are addressing with your early intervention service:

- ☐ No progress, the IFSP team needs to meet and discuss strategies
- ☐ Slight progress
- ☐ Making expected progress
- ☐ Doing great, will continue these services as described on the IFSP
- ☐ Outcome Achieved! The IFSP team needs to meet to discuss eliminating these services or revising the IFSP outcomes to reflect new skills and changing needs.

Provider Signature:	Date
FSC serving child:	Telephone:

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Case Closure/Transfer/Transition Form

Complete this form when a child exits EarlySteps system of services before age 3 (case closure), moves to another SPOE region (transfer) or who exits at age 3 (transition).

Do not use this form to indicate that a child is terminating a service or changing providers.

Section 1: Child Information

Child's name:_____ Date of Birth:_____
Last/first mm/dd/yyyy

Home Address: _____

City/Town: _____ Zip Code:_____ Parish: _____

Case Closure: (Check one)

- □ Parents declined referral
- □ Could not contact
- □ Determined not Eligible
- □ Moved out of State
- □ Completion of IFSP before age 3

Inactivation Date: _____
Mm/dd/yyyy

- □ Parents declined services
- □ Deceased
- □ Did not complete Eligibility
- □ Moved to another region

Transfer to SPOE: (Check one) **Inactivation Date: _____**

Mm/dd/yyyy

□1	□2	□3	□4	□5	□6
□7	□8	□9	□10	□11	□12
□13	□14	□15	□16	□17	□18
□19					

Transition: (Check one) **Inactivation Date: _____**

Mm/dd/yyyy

- □ Moved out of state
- □ Withdrawal by parent
- □ Eligible for IDEA, Part B services
- □ Eligible for IDEA, Part B services and Head Start
- □ Eligible for IDEA, Part B services and other community preschool program
- □ Not Eligible for IDEA, Part B services, no referrals
- □ Not Eligible for IDEA, Part B services, with referrals
- □ IDEA Eligibility for Part B services not determined

Completed by: _____

Date Received by the SPOE:_____Date Entered: _____

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EARLY INTERVENTION SERVICES TRANSITION NOTIFICATION

Child's name:_____

DOB: _____

Parents name:_____

Address:_____

_____

Telephone:

Date:_____

Dear _____,
Parent's name

Your child will soon be turning three. Part C regulations require that we begin planning for the transition out of the Early Steps Early Intervention System at the child's age of 2 year, 6 months. At age three your child may be eligible for services from the local school board (LEA preschool special education) and/or services from the Office for Citizens with Developmental Disabilities (OCDD). Both agencies must begin their specific activities for determining if your child is eligible for services at age three. A delay by the local school in conducting needed assessments and developmental evaluations (testing) may negatively effect your child's current placement on the BCSS Waiver Services Registry and placement for OCDD services.

No earlier than six (6) months prior to the child's third birthday and at least ninety (90) days prior to the child's third birthday, your Early Steps family service coordinator will convene an IFSP meeting to discuss the transition process with you and other team members in order to develop a transition plan. At this time, the team documents the steps to be taken to transition to the public school system and/or other services, such as OCDD. Local school district personnel must be invited to this IFSP meeting.

If you agree to eligibility determination for special education and related services that begin at age three and/or eligibility determination for OCDD services, the Early Steps family service coordinator shall obtain release(s) of information to the public school system and the Regional OCDD office at this meeting. With your consent, the following packet of information will be sent to the school and/or OCDD:

1. Copy of the IFSP (most recent)
2. Copy of the Annual Eligibility Documentation (most recent)
3. Copy of the FSC Quarterly Report (most recent)
4. Copies of Reciprocal Releases of Information
5. Determination Letter of Eligibility

A Consent to Release and Share Information form is provided so that we may send documents to the school and/or OCDD. I will need this signed form returned to me before I can release any information to those agencies. Please feel free to contact me if you have any questions about the transition process. You can reach me at: [insert phone number].

Sincerely,

Family Service Coordinator
Cc: LEA
Regional OCDD office

Other Forms (used as needed by Intake and Family Support Coordinators)

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Consent To Bill Insurance

Instructions

Early Steps must have written parental consent to access private insurance as a payment source for early intervention services.

This form must be signed and dated. Original is placed in child's file located at the System Point of Entry; copies are sent to the parent/family and Family Service Coordinator.

I give permission to Early Steps of Louisiana to use my private insurance as payment for the following early intervention services on my child's IFSP:

__ occupational therapy __physical therapy __speech /language therapy

__assistive technology __counseling __ medical services

__nursing services __health services __psychological services

__nutrition services __vision services __audiological services

__special instruction __social work

I understand that consent to use insurance is voluntary and that Early Steps enrolled agencies may not compel me to file a claim when this action would cause a financial loss. Financial loss includes: a decrease in the available lifetime coverage or any other benefit under the insurance policy, an increase in premiums or the discontinuation of the policy or the out-of-pocket expensed such as the payment of a deductible or co-payment.

Parent Signature _____

Date:_____

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Consent for Specialized Assessment

Instructions

Early Steps must have written parental consent to conduct an assessment for which there has been no previously obtained consent. This form must be signed and dated. Original is placed in child's file located at the System Point of Entry; copies are sent to the parent/family and Family Service Coordinator.

I give permission to Early Steps of Louisiana to conduct an assessment in the developmental domain of: (Check all that apply)

__ motor (gross and fine)
__ communication
__ social-emotional
__ cognitive
__ adaptive (self-help skills)

I understand that consent for this assessment is voluntary and can be revoked by me at any time. I have been provided my Parent's Rights under EarlySteps.

Parent Signature _____

Date:_____

Early Steps Data Correction Form

Date Originally Received at SPOE: _____
Date Sent to FSC: _____
Date Returned to SPOE: _____

TO: _____ FAX:_____

From: _____ FAX:_____

The attached form cannot be entered into the SPOE data system as is. Please note issue listed below and return corrected form to the SPOE. The SPOE must receive the corrected form within 3 days. Attach this page with the corrected form. **Checked items must be corrected.**

IFSP

Page 1:

☐IFSP meeting date ☐ FSC name
☐FSC telephone ☐IFSP History dates:

Page 6:

Column
☐A ☐B ☐C ☐D ☐E
☐F ☐G ☐H ☐I ☐J
☐Section K
☐Parent Signature:

Page 6a AT:
Outcome number
☐Name of device ☐Provider ☐Location of device
☐ When used ☐Start Date ☐End Date
☐HCPCS Code ☐Price

Transportation:
☐ Outcome number ☐ Start Date ☐ End Date ☐ Provider ☐ Frequency ☐ Miles

---

6 Month Review
Column ☐A ☐B ☐C
☐D ☐E ☐F
☐G ☐H ☐I
☐J
☐Section K
☐Parent Signature:

IFSP Revisions
Column
☐A ☐B
☐C ☐D
☐E ☐F
☐G ☐H
☐I ☐J
☐ Section K
☐ Parent Signature:

Change of Information Form

Note: This form is used to indicate changes in address, names due to change in marital status, phone numbers, etc. This form is not to be used to make changes to early intervention services on an IFSP.

Completed By:	**Effective Date: / /**

Current Enrollment Information

Child's Name: _____

DOB: _____/_____/_____

Last First MI

Parent's Name: _____

☐ **CHANGE**

☐ Child's Name: _____
Last First MI

☐ Address: _____
Street City State Zip Code

☐ Address: _____
Parish School District

☐ Phone Number: _____
Person/Location (Area Code) Phone Number

☐ Household Member/Information: _____
Person (Describe Change)

☐ Diagnosis: _____

☐ Other: _____

How did you learn of this change: (Check one)

- ☐ Telephone conversation with parent
- ☐ Face-to-face meeting with parent
- ☐ Telephone conversation with provider
- ☐ Face-to-face meeting with provider

EarlySteps
Provider Change of Information

Note: This form is used to indicate changes in tax identification number, address, names due to change in marital status, phone numbers, etc. This form is not to be used to make changes to early intervention services on an IFSP.

Completed By:	**Effective Date: / /**

Current Information

Provider's Name: _____ Telephone:_____

Provider's Address: _____

Provider's Tax ID:_____ Payee Status: check one ☐ independent ☐ agency

CHANGE: Check all that apply

☐ Proivder's Name:_____ ☐ Address: _____
Street City State Zip Code

☐ Phone Number: _____ ☐ Tax Identification Number: _____

☐ Payee Status: ☐ independent ☐ agency ☐ Other: _____

B. Complete the table below to indicate the changes needed to authorizations. The current authorization will be cancelled and a new authorization with the changed information will be issued.

Legend	Column A	B	C	D	E	F	G	H	I	J Provider's Name/Payee Type
	Early Intervention Service	Outcome Number	Location Code	Frequency	Inten-sity	Start Date	End Date	Method Check ☐ Ind ☐ Group	Fund	☐ Indpt ☐ Agency
Current Service Detail								☐ Ind ☐ Group		☐ Indpt ☐ Agency
								☐ Ind ☐ Group		☐ Indpt ☐ Agency
								☐ Ind ☐ Group		☐ Indpt ☐ Agency

Legend: Current Service Detail to Modify + = Addition of a service - = Termination/Elimination of Service
Location Code: 1 =home or community setting 2 =special purpose center with inclusive child care 3=special purpose center or clinic
Method Code: 1= Early Intervention Service 2= Family Education Training Support 3 = Assessment
Fund Code: A= CFO B= Private Insurance C=MFP D=Other State Funds

FSC CFO Billing Checklist

Directions: Insert Date Activity was completed. Submit original to CFO with Invoice; keep a copy in each child's file.

FSC Name: _____FSC Agency:_____

Child's Name: _____Date of Birth:_____ Authorization Number:_____
Last First MM/DD/YYYY

FSC Billable Activity	Date Completed	Steps for Activity Completion
Ongoing family needs assessment **No signature required**		Telephone or face-to-meeting to review the Family Assessment of Concerns, Resources and Priorities
IFSP Revision		Notification of appropriate IFSP team members sent
		Notice of Action provided to the family
		Team review of progress reports, quarterly reports, early intervention providers data completed
		Completed IFSP Revision Form
Parent/caregiver signature		Completed Change of Authorization Form (as needed) sent to SPOE; copy filed
		Date copies of IFSP Revision sent to all team members
		IFSP Team Minutes (written, disseminated and filed) **OR**
		Dated case note documenting call if changing provider only **AND**
		Completed Parent Request to Change Provider Form sent to SPOE; copy filed
6-month Review		Notification of appropriate IFSP team members
		Notice of Action provided to the family
		Team review of progress reports, quarterly reports, early intervention providers data completed
Parent/caregiver signature		Completed IFSP 6 Month Review Form; sent to SPOE, copy filed
		Completed Authorization Change Form; sent to SPOE, copy filed
		Date 6 month review form copies sent to all team members
		Team Meeting Minutes (written, disseminated and filed)
Quarterly Face-To-Face & Quarterly Report		Date of meeting
		Date completed Quarterly Report sent to SPOE, parents and IFSP team members
		Dated case notes of efforts to obtain monthly progress reports from early intervention providers
Parent/caregiver signature		Date sent to all team members
Annual Re-determination of Eligibility		Notification of Eligibility Meeting to appropriate IFSP team members sent
		Notice of Action provided to the family

FSC Billable Activity	Date Completed	Steps for Activity Completion
		Team review of progress reports, quarterly reports, early intervention providers data completed
Parent/caregiver signature		Completed Eligibility Documentation; sent to SPOE, copy filed
		Team Meeting Minutes (written, disseminated and filed)
Annual IFSP		Notification of appropriate IFSP team members
		Notice of Action provided to the family
		Team review of progress reports, quarterly reports, early intervention providers data completed
Parent/caregiver signature		Completed IFSP sent to SPOE
		Date copy of IFSP sent to all team members
		Team Meeting Minutes (written, disseminated and filed)
Transition		Transition Letter sent to LEA (must be no earlier than child's age of 2.2 and no later than child's age of 2.6)
		Notification of appropriate IFSP team members
		Notice of Action provided to the family
		Team discussion of possible future services and settings
Parent/caregiver signature		Documentation of discussion or training provided to parents about future services
		Documentation of steps to prepare the child for the transition
		Team Meeting Minutes (written, disseminated, and filed)
		Signed and dated Releases of Information (as needed)
		Date information sent to receiving program per parent's written consent
Case Closure		Completed Status Change Form
		Copies of any needed correspondence
No signature required		Date copies of early intervention record sent per parent's written consent
Initial IFSP Meeting **No signature required**		Copy of IFSP team meeting minutes with date and time

Note:

Form Completed by: _____

Date Completed: _____

Appendix Four

EarlySteps Quick Facts

Note: The standard formatting and graphics have been removed in order to reduce the number of pages.